

**The Treatment of Goitre.**—Kocher (*Medical Press and Circular*, May 8, 1901) states that he has performed excision in 1000 cases with the result of only four recurrences. The mortality in normal goitre has been 4 per cent., which includes one death from chloroform and one from cachexia strumipriva. No cases became infected. The dangers of the operation may be distinctly lessened by avoiding general anaesthesia and using Schleich's method of cocaine anaesthesia. As regards non-operative treatment of goitre, that by iodine still plays a useful part in spite of the highly praised and more recently introduced thyroid treatment. Iodide of potassium is to be given with caution, and the thyroid preparation even more so. The author has returned to the old treatment, and advises the use of from six to eight grammes of sodium phosphate daily. The hyposecretion of the goitre is increased by sodium phosphate, and thus diminution in size takes place.

---

## PEDIATRICS.

---

UNDER THE CHARGE OF

LOUIS STARR, M.D.,  
OF PHILADELPHIA,

AND

THOMPSON S. WESTCOTT, M.D.,  
OF PHILADELPHIA.

---

**The Treatment of "Growing Pains" by Aspirin**—J. A. HALE (*Pediatrics*, July 15, 1901, p. 50) follows the most recent opinions as to the rheumatic nature of so-called "growing pains." He has found salicylic acid to be efficient, but often needed in doses that produce distinct toxic symptoms. Salicylate of sodium is objectionable for the same reason, but to a less degree. Both drugs are decidedly irritant to the stomach. Of the newer substitutes for these drugs aspirin has given very satisfactory results, even superior to those of salophen, which is very much better tolerated by the stomach than either salicylic acid or its sodium salt. Aspirin is produced by the action of acetic acid anhydride upon salicylic acid. It undergoes little or no change in the stomach, but is decomposed in the small intestines, liberating the salicylic acid in a nascent state, and leaving the acetic acid to combine with alkalies present to form the beneficial compounds of sodium and potassium acetate.

---

**Stricture of the Œsophagus following Typhoid Fever.**—W. O. ROBERTS, of Louisville (*Pediatrics*, July 1, 1901, p. 15), reports a case of œsophageal stricture following typhoid. According to statistics this is one of the rarest of the sequelæ of the disease, which, according to Keen's collection of 1700 cases in his monograph on *The Surgical Complications of Typhoid Fever*, has been reported only twice. The patient, a boy, aged fifteen years, had suffered from a severe attack of fever, confining him to bed for nine weeks, during which time the diet had been exclusively liquid. Just before he began to sit up, in attempting to swallow a capsule of quinine, he choked,

and had considerable difficulty in finally swallowing it. Since then up to the time of reporting he was unable to swallow any solid food. The smallest sized bougie was stopped at a point about twelve inches below the teeth.

The author states that this is the third case of post-typhoid stricture of the œsophagus that has come under his observation.

**The Iodide of Arsenic in the Bronchitis of Childhood.**—R. SAINT-PHILIPPE (*Revue mensuelle des Maladies de l'Enfance*, July, 1901, p. 337) refers especially to a type of bronchitis observed quite often among rachitic or lymphatic children which he designates as emphysematous bronchitis. Apart from the usual signs of bronchitis there is marked dyspnea, which is aggravated toward nightfall and by the slightest movement, but this is distinguishable from true asthma by the presence of dry or mucous râles. This form of bronchitis is developed usually by some infectious process aided by the diathetic predisposition. Under these conditions the bronchial catarrh induced by the infectious disease, such as diphtheria, influenza, typhoid fever, measles, whooping-cough, or bronchopneumonia, shows little tendency to resolution, and by its delay leads one to suspect the presence of tuberculosis. Most of the children affected with this tenacious bronchitis show the signs of the lymphatic or scrofulous temperament. Some are flabby, indolent, and suffer from eczematous eruptions upon the face, from blepharitis, or coryza, with hypertrophy of the upper lip—in a word, the strumous facies. Others are pale, delicate, and have scrofulous or gouty antecedents; while a third class brings a new element into play in the close relation manifested between efflorescences of the skin and bronchitis, and almost all of these suffer from dyspepsia and gastro-intestinal auto-intoxication.

In such cases the author thinks that the iodide of arsenic is especially applicable. The iodine acts beneficially upon the diathetic condition as an alterative and depurative, and locally upon the circulation and secretions of the whole respiratory tract, while the arsenic supports and stimulates the entire organism. Numerous clinical observations bear out the value of this treatment. Mixed with food this drug is easily borne and is almost tasteless. It is given preferably in water or wine during the meal, or to young children in the milk. It should not be given to children with disturbance of the stomach, lest it aggravate the trouble.

The iodide of arsenic is easily prepared provided the solution is kept cold to prevent the precipitation of hydriodic acid. The formula used is 30 centigrammes of iodide of arsenic to 30 grammes of distilled water. Of this 5 drops may be given at each meal, the dose to be increased by 1 drop morning and evening until 15 or even 20 drops at a dose are taken at each meal. This maximum dose should be continued for about a month, and then gradually decreased in inverse order to 5 drops again. After a rest of eight to ten days the course should be repeated in the same manner as before.

**Acetanilid Poisoning by Absorption from External Wounds.**—MANASSES (*International Medical Magazine*, 1901, vol. x., No. 5) reports two cases, one in an infant, aged six weeks, the other in a child, aged two and one-half years. The first had a dermatitis of the buttocks due to irritating passages, the skin being cracked and abraded. A powder containing equal parts of

acetanilid and subgallate of bismuth was dusted over this surface. Within the next twenty-four hours the child developed subnormal temperature, cyanosis, and other symptoms of acetanilid poisoning. Recovery followed the use of hot baths with whiskey internally.

In the second case the same dusting powder was used for a scald of the buttocks. The local effects were very satisfactory, but on the second day the child complained of coldness, and the lips, ears, and finger-tips were cyanotic. These symptoms lasted for two days, gradually disappearing under the administration of a mixture of strychnine, ammonia, and brandy.

**The Coincidence of Rheumatic Endocarditis with a Congenital Heart Lesion.**—HALLÉ and ARMAND-DELILLE (*Archives de Médecine des Enfants*, 1901, vol. iv., No. 5) report the case of a boy, aged three years, who had always been healthy before the attack of acute articular rheumatism involving ankles and elbows. Attention was drawn to the heart by the rapidity and intensity of its action. At the apex was heard a systolic murmur, transmitted to the back. The area of cardiac dulness extended to the right border of the sternum; the lungs were normal. Death occurred in the third week from cardiac failure after several hours of severe progressive dyspnoea and cyanosis. At the autopsy the heart was found to weigh 180 grammes; the mitral valve was much thickened and presented fresh vegetations, and the foramen ovale was patulous and as large as a one-franc piece.

The case is remarkable for the previous absence of cyanosis or any functional disturbance due to the congenital defect, and for the rapidity with which the terminal symptoms ensued. The case illustrates the rule recently formulated by Marfan: whenever an acquired endocarditis in childhood presents very grave symptoms it is necessary to suspect that it does not exist alone, but is accompanied either by pericarditis or a congenital anomaly of the heart.

**The Feeding of Diphtheria Cases.**—R. G. KIRTON (*The Lancet*, June 15, 1901, p. 1666) emphasizes the great importance of feeding in this disease, a task that is often attended with the greatest difficulty owing to the inability of many patients to take or retain nourishment by the mouth. Feeding may be carried out by (1) the mouth; (2) the nasal tube; (3) the rectum, and (4) subcutaneous injections. In all cases, when practicable, food should be given by the mouth. Certain conditions, however, render mouth feeding impossible or inadvisable. Chief among these are the following: (1) Inability to swallow owing to pain or faucial swelling; (2) some cases of regurgitation; (3) entrance of food into the larynx in spite of slow and careful feeding, indicated by the patient's coughing when fed; (4) in certain cases, owing to struggling, the time taken and the exhaustion consequent upon the mouth feeding; and (5) continued vomiting—(a) vomiting which may be present almost from the onset of the disease; (b) early vomiting, commencing about the middle or end of the second week; and (c) late vomiting, which occurs after some weeks. It is well to remember that cases occur in which patients can be fed with a nasal tube without vomiting, although they vomit when fed by the mouth.

Nasal feeding can be performed with a soft rubber tube, but occasionally a stiff tube is necessary. Generally an interval of four hours is advisable, but

this must depend to a certain extent upon the individual case. Milk peptonized, if necessary, or combined with a cereal food should be the chief ingredient. Raw meat juice, eggs, cream, brandy, or medicine may be added. The quantity must vary with the age, size, etc., of the patient. About four ounces is often as much as a child of from three to five years old will be able to retain and absorb, and even this may need to be reduced. All food should be strained, measured, and given warm. If vomiting occur it may be due to the amount or contents of the meal or to the frequency of administration. If after various changes the vomiting persists, rectal alimentation must be resorted to. It is worth noting that after the first few trials nasal feeding becomes as a rule remarkably easy, owing to the effect of habit, and in some cases to actual loss of sensation.

Rectal alimentation should be resorted to when feeding by the mouth or nose fails or is insufficient. A funnel and a soft rubber tube passed as far up the rectum as possible is preferable to the ball syringe, and the fluid should be allowed to flow in by the force of gravity alone. The food should be given warm about every four hours, and should be preceded about an hour by a feeding of three or four ounces of warm water given in the same manner as the milk feeding. [Physiological salt solution is to be preferred to plain water for this purpose, as it is less irritating to the mucous membrane of the bowel.—ED.] The bowel should be irrigated every twenty-four hours, and it is possible from this to get some idea as to whether the food has been absorbed. The quantity of food thus introduced should depend upon the age of the patient. In young children it varies from two to four ounces. Peptonized milk is the basis of the feeding, and often is the only constituent. Raw meat juice, white of eggs, and occasionally yolk of eggs may be added. In some cases brandy may be added to the milk, and can be tolerated usually for a long-continued period. It may, however, provoke a diarrhoea, and thus may be better tolerated if given apart from the feeding and diluted only with water. Large rectal feedings are inadvisable, since from their bulk they are not long retained and are more apt to set up diarrhoea than the smaller quantities. Diarrhoea is a troublesome and serious complication in these cases, for rectal alimentation has to be depended upon to support life over far longer periods than is usually supposed possible. If the feedings are not retained or only retained in part, their amount should be diminished, their frequency lessened, or some ingredient of the mixture, *e. g.*, brandy, omitted. Sometimes washing out of the bowel and giving it a rest for a time is useful, or starch and laudanum enemata may be required.

In addition to the forms of feeding described the subcutaneous injection of sterile horse serum is to be recommended. This serum should be used when the amount of nourishment taken by the stomach or rectum, or both, appears to be insufficient to support life. Sometimes it offers the only means of feeding the patient, owing to continued vomiting and diarrhoea. If given over a prolonged period, 20 to 40 c.cm. are often as much as it is advisable to inject daily. The only possible indication against the use of these injections is hemorrhage into the subcutaneous tissue adjoining the site of injection. The author, however, has observed no dangerous effects from its use, either from these hemorrhages or other causes.